Monroe E. Trout PREMIER Cares AWARD

18th Annual Premier Cares Award entry form

ENTRY DEADLINE: Entries must be received by Friday, July 31, 2009.

APPLICATION GUIDELINES FOR THE EIGHTEENTH ANNUAL MONROE E. TROUT PREMIER CARES AWARD

1. The program must improve access to the delivery of healthcare services to the medically underserved population of the United States, or otherwise substantially improve health status. This award is intended to recognize a collective effort or project rather than an achievement by an individual or group of individuals.
2. The program must be a not-for-profit entity, in either the public or private sector.
3. The program must be able to show measurable benefits/outcomes covering a full two-year span prior to **Friday, July 31, 2009.**
4. The program must be capable of being replicated.
5. The entry form must be filled out completely. Incomplete applications will be disqualified prior to judging.
6. This year, only **finalists** will be asked to provide a **process map** for their program's development and growth to ensure replicability. Examples of process maps are at: http://www.premierinc.com/about/mission/social-responsibility/cares/process-maps.pdf
7. To see how aspects of your entry will be weighted and scored by the judges, please refer to: http://www.premierinc.com/about/mission/social-responsibility/cares/scoring-sheet.pdf
8. **Please adhere to the page limits specified below for the "Summary" and "Statement of Purpose" sections. Thank you.**

Instructions:

- Save this form to your computer.
- Complete the form and gather all supporting documentation.
- E-mail the completed form to caresaward@premierinc.com.
- If you have not heard from a Cares Award representative within two business days after your submission, please e-mail caresaward@premierinc.com.

Attachments:

- Upload your entire application and attachments at http://sendspace.com/multiupload.html
- Enter: caresaward@premierinc.com as the "Recipient's e-mail".
- **Enter your program name or e-mail address in the "Your e-mail" field.**

If you need assistance with this process, please contact Premier's Solution Center at 1.877.777.1552.

Program name	CenteringPregnancy Group Prenatal Care
Sponsoring organization (if applicable)	Centering Healthcare Institute
Program Web site (if applicable)	http://www.centeringhealthcare.org
E-mail address	srising@centeringhealthcare.org
Mailing address	558 Maple Avenue, Cheshire, CT 06410
Contact person	Sharon Rising, MSN, CNM
Title	Executive Director
Telephone	203-271-3632
Fax	203-272-3460
Is entry associated with a hospital or health system, which one?	No

Section 1: Summary
Provide a brief summary of the program being nominated. Include geographic service area, description of the population(s) served, number of employees and volunteers at work in the program, length of time in existence, brief history, annual total expense budget figures for last two years of operation, major sources of funding, and any other important facts.

Section 2: Statement of purpose

Describe the program's objectives, its approaches to specific community problems, and the actions taken to achieve program goals. Explain how this program is *unique* compared to others across the country. Provide examples of how this program is *innovative and creative* in solving community problems.
Note: If the program is broad-based, concentrate on areas that have been the most successful in terms of community impact, innovation, results, etc. Emphasize "social utility," the impact on local health status, and role the program fills that other initiatives do not.
(Please insert your response here. Please do not exceed two pages.)

Section 3: Outcomes (Not just activity or volume, but actual impact to achieve better health.)
Describe how the program's success and effectiveness are measured. Provide supporting data that shows measurable benefits over a two-year period. Specific outcomes information should include: number of people directly impacted, improvement in health status indicators, examples of how the program has been replicated (if applicable), positive behavior change, improved access to services, etc. Charts and graphs of the program's impact over time are helpful.
(Please insert your response here. Please ensure that all text and graphics/charts are visible. If your response does not fit cleanly on the page, please upload your response as a separate attachment using the instructions above.)

Section 1: Summary

CenteringPregnancy is the first innovation in prenatal care in approximately 100 years. First piloted by Sharon Schindler Rising, CNM, MSN, in 1993, this redesign brings women out of the exam room into a group setting where they receive basic prenatal checkups, build community with other women, and gain knowledge and skills in pregnancy, childbirth and parenting. Two healthcare providers facilitate groups of 8-12 women of similar gestational ages. Instead of short visits alone with a provider, CenteringPregnancy has ten 120-minute sessions from about week 14 of pregnancy through one-month postpartum. That is, 20 hours of prenatal care across pregnancy, compared to about 2 hours – at no additional cost.

CenteringPregnancy care is provided in more than 300 sites in the U.S including, hospital, public health, and school based clinics, federally qualified health centers, and private practices. This model of group prenatal care serves the general needs of all pregnant women and meets the special needs of racial and ethnic groups. Women in Centering groups have varied socio-economic backgrounds ranging from low literacy to college graduates, rural and urban, US born as well as refugees. Groups in the U.S. have been conducted in several languages e.g., Spanish, Chuukese, and Vietnamese allowing for culturally sensitive care. This prenatal care model transcends barriers to bring women together to share what they have in common: the desire to have a healthy baby and a safe, satisfying labor and delivery experience.

Centering Pregnancy is consistent with the Monroe E. Trout Premiere Cares Award criteria as follows:

1. **Innovation:** Prenatal care is taken from individual experience into group care providing assessment, education and support. This is a major paradigm shift in the delivery of prenatal care.
2. **Outcomes:** CenteringPregnancy reduces premature births and improves other maternal child health outcomes including breastfeeding rates, return for postpartum visits, and pregnancy spacing, and satisfaction as shown in randomized controlled trials and other studies.
3. **Replicability:** The model exists in more than 300 sites throughout the U.S., Canada and other countries and is highly replicable. The model is used in education and training of future midwives and doctors. Additionally, site training and follow-up agency support is well established.
4. **Evaluation methodology:** CenteringPregnancy has been the focus of several federally and philanthropically funded studies and is currently being evaluated in a large translational randomized controlled trial in New York City.
5. **Strength of supporting documents:** References from a large body of published data have been provided. Letters of support echo the message that Centering is an innovation with profound impact that has been replicated and has a strong evaluation base.

The Centering Healthcare Institute (CHI) (formerly Centering Pregnancy and Parenting Inc.) a 501c3 organization founded in 2001 provides services to help health care providers throughout the U.S. implement CenteringPregnancy group care. Six office staff support the coordination of training workshops, consultation, and development and disbursement of patient recruitment and education materials. Approximately 40 contracted professionals throughout the U.S. conduct training workshops to prepare providers to implement CenteringPregnancy in their setting. There is a large body of supporters and volunteers around the country and beyond called upon for outreach, sharing resources, and moral support for sites implementing change.

CHI receives income from agencies and providers for training, consultation and materials that support patient education. Expenses include salaries and contract labor, development and production of programs and materials, promotion, and site support. Profits are reinvested into the organization for the development and promotion of the Centering Models of care.

Insurers reimburse CenteringPregnancy care the same as traditional care. Clinical sites invest in the model to improve the way they provide care and improve patient and provider satisfaction. March of Dimes has helped dozens of sites with start up costs through state grants in excess of $1.5 million, because of the impressive outcomes in studies that indicate this is a fit with their campaign to reduce prematurity.

2007 and 2008 Centering Budget Summary		2007	2008
Income	Training, consultation, sales to sites implementing Centering programs	$ 498,826	$1,068,887
Expenses	Develop, promote and implement Centering programs and products	$ 461,708	$ 887,997
Net Income	Reinvested to further develop and expand Centering models of care	$ 37,117	$ 180,890

Section 2: Statement of purpose

CenteringPregnancy is an innovative model for providing complete prenatal care to women within a group setting. CenteringPregnancy is based on the premise that prenatal care is most effectively and efficiently provided to women in groups. CenteringPregnancy groups provide a dynamic atmosphere for learning and sharing that is impossible to create in a one-to-one encounter. Individual care provides limited contact with providers, typically does not provide support services, and is often too fragmented to respond to the complex needs of pregnant women. Hearing other women share concerns, which mirror her own helps the woman normalize the experience of pregnancy. Groups are empowering as they provide support to the members and increase individual motivation to learn and change. Providers and patients report greater satisfaction with group compared to traditional care and the natural extension of prenatal care has led to CenteringParenting[1] groups continuing well baby and well woman care through the first year postpartum.

In 2001, the Institute of Medicine published a seminal document, *Crossing the Quality Chasm*, that established 10 rules for the redesign of health care. The 13 Essential Elements that define the Centering model address all of these to improve prenatal care. (Comparison table Section 3: Outcomes) The Essential Elements establish the framework and conditions that intentionally create a patient-centered environment in which traditional hierarchal relationships are broken down and shared leadership occurs. Furthermore, the standards include assessment of outcomes that allow clinical providers to identify changes and flexibility to make adjustments that best fit with their clinical setting and for their patients, healthcare providers, and ancillary staff.

Essential Elements that define CenteringPregnancy

1. Health assessment occurs within the group space
2. Women are involved in self-care activities
3. A facilitative leadership style is used
4. Each session has an overall plan
5. Attention is given to the care content; emphasis may vary
6. There is stability of group leadership
7. Group conduct honors the contribution of each member
8. The group is conducted in a circle
9. Group size is optimal to promote the process
10. The composition of the group is stable, but not rigid
11. Involvement of family support people is optional
12. Opportunity for socialization within the group is provided
13. There is on-going evaluation of outcomes

CenteringPregnancy prenatal care brings together 8 – 12 women of similar gestational age for ten 2-hour sessions starting at approximately 14 weeks gestation. The sessions start and end on time, eliminating a common waiting time before appointments. During the first 30 minutes, women obtain their own blood pressure and weight, determine their gestational age, and record the data in their health record. Then, individually, women take turns in a private area within the group space for a brief assessment and triage with the provider to listen to the baby's heartbeat, measure uterine growth, and speak about specific concerns. General questions of interest to most women such as how to deal with back pain are brought to the group so all will benefit. Food to encourage socializing and music playing in the background make for a welcoming atmosphere. Each woman has a Mom's Notebook divided into 10 sessions with materials related to educational content areas. A Self-assessment sheet (SAS) allows each person to review information and is a resource for later discussion. After check in and assessments, everyone is seated in a circle and the provider and co-facilitator encourage discussion about the educational information for that session. Initially introductions take place and group guidelines and confidentiality are addressed. Interactive exercises allow participants to get to know each other, relax, and talk about subjects of common interest. Knowledge, beliefs, and experiences are shared at whatever level is personally comfortable. The women, provider and nurse spend about 60 to 90 minutes together exploring ideas and information.

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[1] CenteringParenting is currently provided in several U.S. sites, and a study of this model is underway at Yale. Further model expansion includes lifecycle applications for chronic health conditions with CenteringDiabetes taking the lead.

CENTERINGPREGNANCY® Session Outline & Self Assessment Sheets (SAS)

Session 1 Program overview, ground rules, nutrition
SAS: Personal Goals, Core Content Ranking, Weight Chart

Session 2 Common complaints of pregnancy, exercise, oral health
SAS: Common Discomforts

Session 3 Relaxation/stress reduction, breast feeding, parenting issues
SAS: Relaxation Methods, Thinking About Breastfeeding

Session 4 Relationship issues, sexuality, contraception, preterm labor
SAS: Contraceptive Issues, Family Assessment

Session 5 Signs of labor, birth procedures
SAS: Personal Goals update from Session 1

Session 6 Labor/birth continued, pediatric care resources
SAS: Comfort Measures for Labor, Self-Inventory

Session 7 New baby care, breast feeding, siblings, oral health
SAS: Decisions of Pregnancy, Evaluation I

Session 8 Emotional adjustment postpartum, support system, birth concerns
SAS: Personal Assessment

Session 9 Birth concerns/stories, postpartum issues, playing with your baby
SAS: Pregnancy Review Sheet; Thinking Ahead

Session 10 Continued birth stories, pregnancy/birth/postpartum newborn
SAS: Evaluation II, Final Summary of Outcomes

Groups are powerful vehicles to assist participants to achieve goals that would be unattainable by individuals. CenteringPregnancy is founded on the philosophy that pregnancy is a process of wellness and a time when many women are likely to take responsibility for their own health and learn to participate in self-care. The general advantages of group interventions include improved learning and skills development, attitude change and motivation and enhanced insight development through sharing of common life experiences. In turn, groups can hasten the development of new community norms for health enhancing behaviors that are supported by members of the group. In this way, groups provide inherent support for individual members. Finally, groups may be cost effective through more efficient use of professional and staff time.

All women may benefit from participating in a group in which shared experiences reduce a sense of isolation, of being "the only one with a problem." However, Centering is especially useful to address disparities for women who are isolated socially and/or at increased risk for adverse outcomes. One woman's questions are another woman's questions. A Spanish-speaking woman in an English speaking group expressed that she was very glad to be in a group with other women who asked questions that she had but was reluctant to voice. A group of women can be a powerful influence to encourage change. In one prenatal group, a teen mom shrugged in response to a discussion about birth control methods after delivery. She received strong messages from the other women that she should not get pregnant right away. At the next prenatal visit, she proudly announced she had a plan for birth control and received positive feedback from the group. In a clinic where TB rates are very high and compliance with treatment is about 50%, a group of pregnant women were able to "normalize" having positive TB results and they had a 100% compliance with treatment postpartum.

The innovation of the Centering model is poised to change the paradigm of care, shifting the focus of healthcare service delivery from the priorities and values of the system or provider to the beneficiaries of care: women and their families. In so doing, community building and empowerment of women and families are encouraged, costs are reduced, satisfaction is increased and outcomes are improved. It is the goal of CHI that every woman who would like group prenatal care is able to find a site that can provide it.

Section 3: Outcomes

Most pregnancy women and their infants are healthy and at low risk. Yet maternal and newborn hospital charges ($86 billion in 2006) exceed those of any other condition according to Childbirth Connection, a leading organization in the promotion of safe, effective and satisfying evidence-based maternity care. Despite great advances in technology in obstetrical technology, only the costs are increasing, while outcomes decline. Women and infants bear that price. In 2009, Childbirth Connection put forth recommendations for health care reform that suggest "women and infants are best served by access to safe, low-intervention primary maternity care that supports their innate capacities for birthing, breastfeeding and attachment, avoids overuse, and gives priority to prevention, wellness, and appropriate referral and treatment as needed." CenteringPregnancy group care helps women understand how to navigate a complicated healthcare system and take an active role in determining how their needs can be met with the right type of care when it is needed.

Infant mortality is an important indicator of a nation's health. Among the leading causes of death in infants are preterm birth and low birth weight. Low birth weight is a major threat to the health and well-being of infants. Low birth weight infants are at much greater risk of dying before their first birthday. Those who survive are at an increased risk of neurological problems, mental retardation, lower respiratory tract condition and general morbidity. Furthermore, studies suggest that individuals born with low birth weight may be at risk for chronic conditions in adulthood including high blood pressure, heart disease and diabetes. Sixty three percent of low birth weight is due to preterm births. "Preterm birth is the leading cause of death in the first month of life in the United States. Since 1990, the preterm birth rate has increased almost 20 percent costing the nation more than $26 billion a year" according to a 2006 Institute of Medicine report.

Many known risk factors associated with low birth weight such as ethnic background, socio economic status and obstetric history are beyond a woman's control. However, lifestyle behaviors such as weight gain during pregnancy, use of alcohol and other drugs, and risk behaviors are within a woman's control and may be influenced by education and group support. Stress from lack of partner or maternal support contributes to poor birth outcomes and may be mediated by social support and stress reduction techniques that can be taught.

CenteringPregnancy has been the subject of peer-reviewed published studies, including two randomized controlled trials in which, statistically significant improved outcomes for participants in the group care versus those in traditional individual care have been documented. These differences include reduction in preterm birth, low weight infants, and significantly increased patient satisfaction with care in groups. Comparison of CenteringPregnancy group prenatal care to individual care has consistently shown improvements among group care participants. Of particular interest, are findings that populations known to be at increased risk such as teens and African American women may see even greater results. In a randomized controlled trial of 1047 young women (ages 14-25) in New Haven CT and Atlanta GA, Ickovics and colleagues documented a 33% reduction in preterm births across all participants. In a subset analysis of African American women, who represented 80% of the sample, there was a 41% reduction in preterm births. While the mechanism is not clearly understood, themes are emerging to suggest that CenteringPregnancy has a combined effect of stress reduction, education and empowerment that bring about a dramatic effect.

SELECTED STUDIES AND SUMMARIES

Group Prenatal Care and Preterm Birth Weight: Results From a Matched Cohort Study at Public Clinics Ickovics 2003

Prospective matched cohort study involving 458 women conducted to determine the impact of group versus individual care on birth weight and gestational age.

Findings: Group prenatal care results in higher birth weights especially for infants born preterm. Of those who delivered preterm, women in group care delivered infants that were two weeks older and one pound larger.

Table 2. Birth Outcomes Stratified by Treatment Group

	Centering group prenatal care (n = 229)	Individual prenatal care (n = 229)	P
Birth weight (g)	3228.2 (540.1)	3159.1 (640.7)	<.01
Preterm	21 (9.2)	22 (9.6)	.83
Early (< 33 wk)	2 (0.9)	7 (3.1)	
Late (33–36.9 wk)	19 (8.3)	15 (6.5)	
Low birth weight (< 2500 g)	16 (7.0)	23 (10.0)	.38
Very low birth weight (< 1500 g)	3 (1.3)	6 (2.6)	N/A*
Neonatal deaths	0 (0)	3 (1.3)	N/A*

Abbreviation as in Table 1.

Data are presented as *n* (%), except birth weights (top row), which are mean (standard deviation).

* Cell sizes too small to permit statistical testing.

Ickovics. Group Care Improves Birth Weight. Obstet Gynecol 2003 pg 1054

Average birth weight for preterm and term infants stratified by group vs individual care

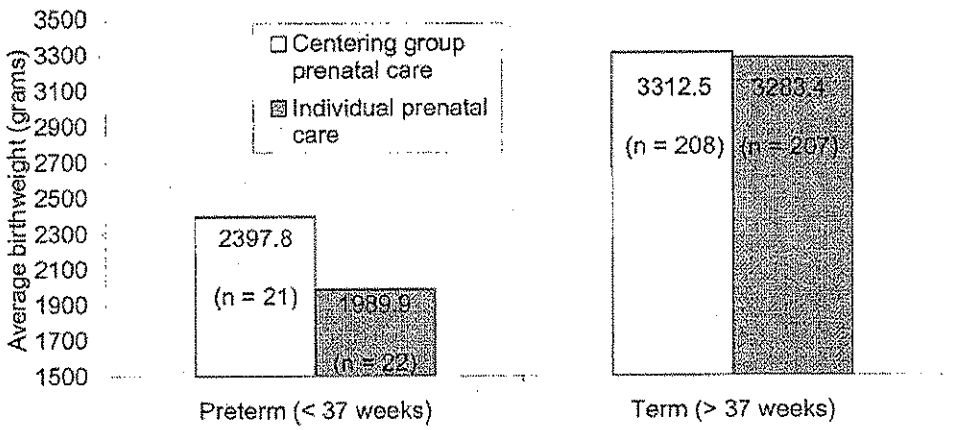


Figure 1. Average birth weight for preterm and term infants, stratified by group versus individual prenatal care.

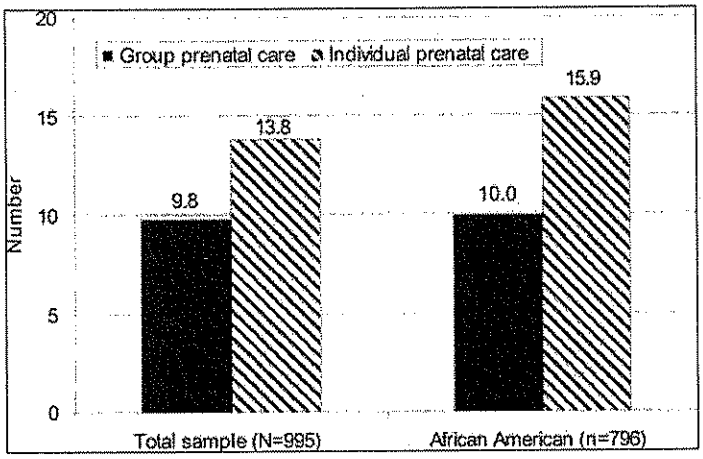
Ickovics. Group Care Improves Birth Weight. Obstet Gynecol 2003.

Group Prenatal Care and Perinatal Outcomes A Randomized Controlled Trial Ickovics 2007

Randomized control group involving 1047 women in public clinics in 2 cities (New Haven, CT and Atlanta, GA) compared the effects of prenatal care between those in Centering group care and individual care.

Findings: Women randomly assigned to group care were significantly less likely to experience preterm birth. Overall women in CenteringPregnancy group care experienced a 33% lower rate of preterm birth and African American women (representing 80% of the sample had a 41% lower rate of preterm birth. CenteringPregnancy is more multifaceted than many other clinical and psychosocial interventions that seek to augment care with more visits or more information using didactic approaches, which may be one reason for these relatively favorable outcomes.

Fig. 2. Preterm delivery for total sample and African Americans only.



All analyses were controlled for factors that were different by study condition ($P \leq .10$), despite randomization(race, age, prenatal distress, history of preterm birth) and clinical risk factors strongly associated with birth outcomes (smoking, prior miscarriage or stillbirth). Total sample: odds ratio (OR) 0.67, 95% confidence interval (CI) 0.44–0.99, $P \leq .045$; African American only: OR 0.59, 95% CI 0.38–0.92, $P \leq .02$.
Ickovics. Group Prenatal Care and Perinatal Outcomes. Obstet Gynecol 2007.pg 336

Survival curve illustrating comparison of outcomes in traditional and Centering group care.

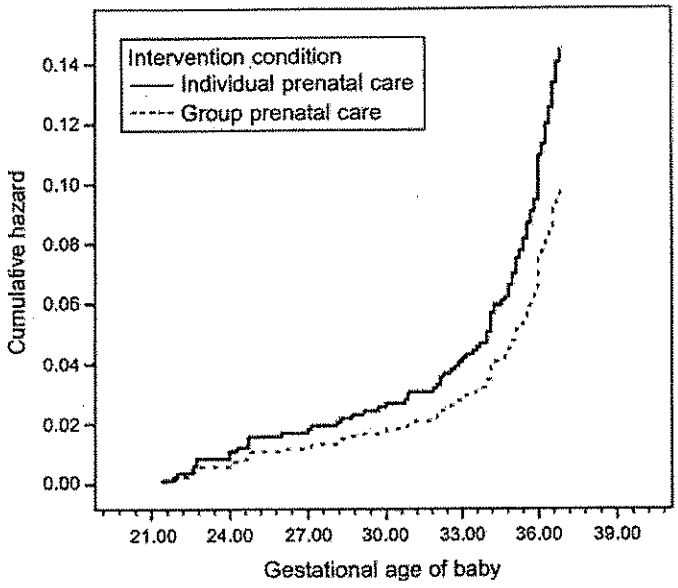


Fig. 3. Hazard function for preterm birth. *Ickovics. Group Prenatal Care and Perinatal Outcomes. Obstet Gynecol 2007.pg 336*

CenteringPregnancy Smiles: implementation of a small group prenatal care model with oral health. Skelton 2009

Program evaluation: A rural Kentucky county with the worst perinatal outcomes in the state implemented CenteringPregnancy in 2006 with an added oral health component: CenteringPregnancy Smiles. The level of poverty among participating women was very high with > 80% on Medicaid. The oral health status for this population was very poor and that was the primary target for the intervention using CenteringPregnancy as a vehicle for added oral health exams, treatment and education.

They conducted the CenteringPregnancy Smiles program for 410 women over two years and found preterm birth rates reduced from 14% to 6 % and rates of low birth weight deliveries from 8 % to 5 %. The improvement was greater than the estimated 20% of adverse birth outcomes that could be linked to oral infections based on previous studies. The authors deduced a synergistic benefit was achieved.

They estimate a savings of $1.5 million in medical bills by preventing 37 preterm births.

Table 2.

BIRTH OUTCOMES AND PRENATAL CARE FOR SINGLETON BIRTHS: DESCRIPTIVE DATA

	Group prenatal care—2006–07 (n=132)	Regional births in 2004[a]	Kentucky births in 2004[a]	National births in 2004[a]
Birth outcomes and prenatal care				
Preterm birth (%)	6.6	13.7	12.6	10.8
Gestational age[b]	39.1 ± 3.0	NA	NA	NA
Low birth weight (%)	5.3	7.3	7.0	6.3
Birth weight[c]	3365 ± 568	NA	NA	NA

[a]March of Dimes Foundation. March of Dimes Foundation website. White Plains, NY: 2009. Available at: http://www.marchofdimes.com/.
[b]weeks, w ± SD
[c]grams, g ± SD
NA = not available

CenteringPregnancy group prenatal care: promoting relationship-centered care. Massey 2006

It is important to understand the mechanisms by which Centering has had its clinical outcomes in order to replicate the positive health outcomes and to consider its application as a best practice model of care in a variety of settings. Themes have been identified in studies that indicate the 13 Essential Elements that define Centering Models establish the basis for the success of this relationship-based approach. Qualitative studies demonstrate the correspondence of Centering with leading recommendations for health care improvement such as the Institute of Medicine's Ten Rules for Health Care Redesign.

Massey and colleagues compared the IOM's Rules for Health Care Redesign and grafted on Centering Essential Elements. As such, Centering is demonstrated as an exemplary model of relationship based care.

Correspondence of CenteringPregnancy® Essential Elements with the Institute of Medicine's Rules for Health Care Redesign

IOM's Rules for Health Care Redesign	Essential Elements of CenteringPregnancy®
Care is based on continuous healing relationships.	Continuity and stability of group leadership Group composition is stable, but not rigid Facilitative leadership
Care is customized according to patient needs and values.	Each session has an overall plan; emphasis varies with group needs Facilitative leadership Opportunity for socialization is provided
The patient is the source of control.	Women are involved in self-care activities Facilitative leadership
Knowledge is shared and information flows freely.	Each session has an overall plan; emphasis varies with group needs Facilitative leadership Group is conducted in a circle
Decision-making is evidence-based.	There is on-going evaluation of outcomes
Safety is a system property.	Women are involved in self-care activities Group is conducted in a circle Continuity and stability of group leadership Involvement of family support people is optional
Transparency is necessary.	Women are involved in self-care activities There is on-going evaluation of outcomes Group is conducted in a circle
Needs are anticipated.	Facilitative leadership Each session has an overall plan; emphasis varies with group needs
Waste is continuously decreased.	Health assessment occurs within the group space Continuity and stability of group leadership
Cooperation among clinicians is a priority.	Non-hierarchical cooperation occurs between different service providers

Pregnancy outcomes of adolescents enrolled in a CenteringPregnancy program. Grady 2004

Evaluation of 124 teen moms who received prenatal care in CenteringPregnancy groups demonstrated both improved outcomes and high satisfaction scores. The Centering group had a low rate of preterm delivery (10.5%) and low birth weight infants (8.9%) and the cesarean rate was 13.7%. The mean satisfaction score was 9.2 out of 10.

Table 3. Responses to Evaluation II: Group Care

Question	Yes n (%)	No n (%)	Don't Know n (%)
Did you get to know other women in the group?	86 (98)	2 (2)	
Were you comfortable having your physical assessments in the group setting?	84 (96)	3 (3)	
Would you rather have had your physical assessment in an exam room?	19 (22)	65 (74)	3 (3)
Did you feel satisfied that the assessment was adequate?	87 (99)	1 (1)	
Was it OK with you to have men in the group?	84 (95.5)	4 (4.5)	
Was it OK to have men present in the room during the physical assessment?	75 (85)	13 (13)	
Do you think it is important to get the group together once or twice after you deliver?	85 (97)	3 (3)	
Are you planning to keep in contact with any of the other group members?	50 (57)	37 (42)	1 (1)

From 12 of 13 Centering groups, 88 of 113 participants responded: 77.9% response rate.

Grady MA, Bloom K. (2004) Pregnancy outcomes of adolescents enrolled in a CenteringPregnancy program. Journal of Midwifery & Women's Health, 49(5): pg 416

Table 4. Demographic Characteristics and Outcomes of the Centering and Two Comparison Groups

	Centering n = 124	2001 Comparison Group n = 144	1998 Comparison Group n = 233
Age [mean (SD)]	15.85 (1.2)	16.5 (0.9)*	16.3 (1.2)*
Race			
African American (%)	116 (93.6)	130 (90.3)	198 (85.0)*
Caucasian (%)	6 (6.3)	13 (9.0)	35 (15.0)*
Other (%)	1 (1.0)	1 (0.7)	0 (0.0)
Preterm deliveries <37 wk (%)	13 (10.5)	37 (25.7)†	54 (23.2)*
Low birth weight <2500 g (%)	11 (8.87)	33 (22.9)†	42 (18.3)*
Cesarean births (%)	17 (13.7)	21 (14.6)	37 (15.9)

* $P < .05$ compared to Centering group.

† $P < .02$ compared to Centering group.

Grady MA, Bloom K. (2004) Pregnancy outcomes of adolescents enrolled in a CenteringPregnancy program. Journal of Midwifery & Women's Health, 49(5): pg 4

CenteringPregnancy® Bibliography

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St. Peter's Medical Group
Broadway
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July 20, 2009

Re: Premier Cares Award

Centering Healthcare Institute.
Award for Centering Pregnancy

Centering Healthcare Institute's Centering Pregnancy Program is a clear improvement in the delivery of Prenatal Care to all women. Our practice has been working to include evidence based medicine in all of our care. For many years we have been delivering standard individual care to pregnant women with little assessment of outcome. At last we have evidence that we can make a difference.

Helena is a small, rural Montana town of 29,000. Our small, hospital-owned clinic began offering Centering Pregnancy as an option to women two years ago. The data are clear. There is a reduction in pre-term delivery and for those that deliver early there is an additional two weeks of gestation. I have been doing obstetrics since 1984. The only other thing that has had this much impact is fetal kick counts developed by the Navy in 1986. There is no added cost and there is clear benefit. We spend a lot of time and effort avoiding lawsuits. This program actually improves care. With one other clinic in Montana we are providing a model that the Indian Health Service is looking to implement.

Our group has reached a point where we believe women need to give informed consent to remain in individual care, rather than group care. Centering Healthcare Institute has a philosophy of collecting data and acting upon the information for a process of quality improvement. It is exciting to be involved in the developing edge of medicine.

The Centering Pregnancy Model is being implemented across the nation with similar results and it is being used as a model for well child care, diabetes, heart disease and many other chronic illnesses. It does not just help the under served. It is open to all comers and there is benefit to all of them. Group care and support will continue to expand. And the model will come back to Centering Pregnancy.

It is an honor and a privilege to write this letter of support for their nomination for the Premier Cares Award.

Thank you.

Richard P. Sargent, MD

MONTEFIORE MEDICAL CENTER
The University Hospital
for the Albert Einstein
College of Medicine

OBSTETRICS & GYNECOLOGY
AND WOMEN'S HEALTH

ALBERT EINSTEIN
COLLEGE OF MEDICINE
OF YESHIVA UNIVERSITY

July 29, 2009

To Whom It May Concern:

I am pleased and honored to write this letter of support for CenteringPregnancy Program. I am very familiar with this Program and feel that it would be an ideal recipient of the Premier Cares Award. Our organization was trained by Centering Healthcare Institute in November 2001 in the CenteringPregnancy program and we have since instituted the Program in several of our outpatient offices at Montefiore Medical Center.

Montefiore Medical Center is the leading provider of healthcare in the Bronx, New York. It operates a large network of ambulatory care offices, many that focus their resources on patients at significant risk of poor outcomes. The Montefiore office at which I see patients is a community health center that delivers about 1,000 women each year. That office primarily cares for indigent women with a variety of needs. We first implemented this model of care in early 2002 and have found it an ideal way to better address the issues that our patient encounter.

This remarkable Program provides routine prenatal care plus all of the things that should be a part of routine prenatal care but providers often do not have the time to address. For example, the Program offers pregnant women and their partners the opportunity to learn about nutrition, contraception, the process of labor and delivery, and care of newborns. All this is provided in a group setting where women learn from each other and are able to create a support network. The providers who lead the groups facilitate them rather than simply teach the participants. This allows the participants to gain confidence in their own judgement and validate the lessons they have learned. They are able to form truly nurturing bonds among themselves and with their providers.

Our anecdotal findings that this is a superior way to provide prenatal care have recently been confirmed in a well designed clinical trial that randomized inner-city adolescents who were pregnant to Centering or traditional prenatal care. In that study, during the period of follow up (1 year after the delivery), the investigators found increased rates of breastfeeding, fewer sexually transmitted infections, fewer repeat pregnancies, and interestingly, fewer preterm births in the index pregnancies. All from a program that incurs minimal additional costs for the agency that implements the model.

We have also found that the program is ideal for training residents in obstetrics and gynecology. Centering allows them to spend time getting to know their patients, learning about their needs and concerns more fully than can be achieved in the typical 10 minute office visit. Through this Program providers, on average, are able to spend 20 hours with their patients instead of only two hours. This allows them to really get to know their patients and to understand their concerns.

Women who have participated in the Centering Program in our office have raved about it. On anonymous surveys that we have done, they rate the program only with superlatives.

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If I can be of any further assistance, please do not hesitate to contact me. This is an important Program that allows prenatal care providers to provide the sort of care that we would like to provide, but can't in a healthcare environment that requires us to see more and more patients in shorter and shorter periods of time. I truly believe that this Program should become the default model of how prenatal care is provided. I feel privileged to be able to write this letter in support of the Centering Healthcare Institute

Sincerely,

Peter Bernstein, MD, MPH
Professor of Clinical Obstetrics &
Gynecology and Women's Health

Yale University

Jeannette R. Ickovics, PhD
Professor of Epidemiology and Public Health
Director, Social and Behavioral Sciences
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29 July 2009

Dear Members of the Search Committee for the 18th Annual Monroe E. Trout Premier Cares Award:

I am pleased to write the strongest possible letter of support for **The Centering Healthcare Institute** in their application for the 18th Annual Monroe E. Trout Premier Cares Award. I have worked with the organization since 2001, when we received funding from the National Institutes of Health to conduct a large 2-city randomized controlled trial to evaluate CenteringPregnancy, group prenatal care. The evidence is clear: women randomly assigned to CenteringPregnancy had clinical, behavioral, and psychosocial outcomes as good or better than those who received standard individual prenatal care. For example, we found that women randomly assigned to CenteringPregnancy were 33% less likely to have preterm delivery (Ickovics et al., Obstetrics & Gynecology, 2007) and 50% less likely to have rapid repeat pregnancy (i.e., within 6 months) or an incident sexually transmitted disease in the first postpartum year (Kershaw et al., American Journal of Public Health, 2009/in press). We achieved better outcomes with no difference in cost.

Based on these successes, we were again funded by the National Institutes of Health to do a large translational study in New York City (2006-2011). We are currently collaborating with The Community Healthcare Institute as well as with Clinical Directors Network, Inc. on a 14-site translational study. The purpose of this new study is to try to replicate our initial outcomes as well as add process outcomes (uptake, fidelity, sustainability), and cost effectiveness. To date, we have fully recruited and randomized 14 community hospitals and health centers across all 5 boroughs of New York, and individual patient recruitment is underway. Our target is 100 young women aged 14-21 per clinical site for a total of 1400 participants. Demographically, these are primarily Black and Hispanic young women, traditionally vulnerable and underserved – and for whom CenteringPregnancy may have the greatest impact.

Sharon Schindler Rising and her colleagues at The Centering Healthcare Institute are committed to innovation and to the best in evidence-based practice – two fundamental goals of Premier Cares. In short, CenteringPregnancy simply transforms the way prenatal care is delivered. I have seen CenteringPregnancy implemented across more than a dozen clinical sites. I can assure you that it is also highly replicable.

Since the application does a good job of describing the CenteringPregnancy purpose and outcomes, I'd like to describe some of the benefits I have observed as part of this innovative model of prenatal care for clinical sites, health care providers and patients themselves. For the clinical sites, CenteringPregnancy promotes greater access to prenatal care and its complementary services. It can maximize time of support personnel (e.g. social worker, nutritionist, counselors, and translators) to increase efficiency. CenteringPregnancy presents an attractive program to the community that has led to favorable publicity,

and attracted new patients to the clinical site. It can reduce traffic and confusion in the health centers, leading to higher satisfaction among administrators, providers, and patients. Finally, there are many financial incentives as well. CenteringPregnancy is fully reimbursable, and can provide for enhanced billing for bundling of complimentary services (e.g., education, counseling, nutrition, smoking cessation). With women in a group space, CenteringPregnancy frees up exam rooms for other paying procedures. Incentive payments through better performance may also be possible, depending on the health system.

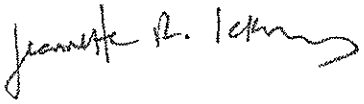
For providers, CenteringPregnancy is advantageous in increasing contact time and improving continuity of care. It is a more efficient use of time and more efficient way to share information around a broad range of services, including but not limited to nutrition, substance abuse, labor preparation, breastfeeding, and parenting skills. In this way, CenteringPregnancy integrates care with education and with community development.

Finally, for patients, CenteringPregnancy increases contact time with healthcare providers dramatically: 2 versus 20 hours of prenatal care – all scheduled in advance. Within this additional time, the quality of care is also substantially enhanced: promoting patient self management and empowerment, as well as the opportunity to discuss more issues into greater depth. Patients and providers can address physical/psychosocial changes and the behavioral changes required to maintain healthy pregnancy, exposing all women to all information, including those too embarrassed to ask a particular question. Both formal and informal support are enhanced. And CenteringPregnancy is flexible enough to adapt to cultural differences, providing exceptional prenatal care for patients and their families.

The Centering Healthcare Institute has a clear vision and set of professional goals. Moreover, the leadership and staff have the integrity, dedication and perseverance to achieve these goals. Over the years, I have been very fortunate to work with an extraordinarily accomplished group of collaborators. The Centering Healthcare Institute is notable in many ways, including never resting on their considerable laurels, but always striving to improve the quality of their approach. They are eager to establish CenteringPregnancy programs around the country and around the world to improve prenatal care and perinatal outcomes for all women.

In closing, I believe that The Centering Healthcare Institute would be an excellent recipient of the 18th Annual Monroe E. Trout Premier Cares Award. I am confident that they will continue to develop and implement this innovative prenatal care model – as well as develop further innovations in pediatrics and care for chronic disease. If you have any questions or would like any additional information, please do not hesitate to contact me. Yours in health --

Sincerely,



Jeannette R. Ickovics, Ph.D.
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